I. INTRODUCTION

The medical community and policy-makers have widely accepted peer review of physicians as essential to encouraging high quality medical practice. Peer review is a process by which members of a hospital's medical staff review the qualifications, medical outcomes and professional conduct of other physician members and medical staff applicants to determine whether the reviewed physicians may practice in the hospital and, if so, to determine the parameters of their practice.

To encourage peer review, almost all states have granted immunity to participants in the peer review process from certain actions and have made the deliberations and records of medical peer review privileged from judicial disclosure. These laws protect peer review participants from liability for their participation in the peer review process and keep medical peer review information privileged even if such information is relevant and probative to a judicial proceeding. In granting these protections, legislatures have determined that limiting the rights of physicians to seek damages for peer review actions and denying malpractice plaintiffs and other litigants information relevant to their lawsuits are justified in order to encourage effective peer review. Remarkably, these laws have flourished at a time when privilege and immunities in other contexts have eroded.

II. SUMMARY OF STUDY AND FINDINGS

National policy seeks to encourage peer review through protective legislation as opposed to imposing sanctions on hospitals and physicians for failing to perform such review. Although all states offer some type of protection to the peer review process, the type and strength of such protections vary across the states. State laws generally grant protection in one or more of three ways: (1) providing peer review participants immunity from lawsuits for participating in the process; (2) making peer review information privileged from discovery and admission in court; and (3) requiring that the participants in the process keep information regarding the process and its findings confidential. Most states also require hospitals that have made certain peer review decisions restricting a physician's medical practice to report such actions to state authorities and a few states have enacted significant penalties for failure to do so.

The federal government addressed the issue of encouraging peer review through statutory protections when Congress enacted the Health Care Quality Improvement Act of 1986 (HCQIA). This Act has two purposes. The first was to grant immunity to peer review participants. HCQIA provides immunity for peer review participants, but does not grant a federal evidentiary privilege to the records and deliberations of the peer review process The second purpose of HCQIA was to create the NPDB, a national clearinghouse of information, to prevent physicians who had their clinical privileges at a hospital limited due to quality problems from moving to other hospitals with impunity. Beginning in September 1990, HCQIA required all hospitals to report to the NPDB certain peer review actions resulting in limitations to a physician's medical staff or clinical privileges and to report when physicians voluntarily surrender their medical staff privileges in lieu of facing a peer review investigation.

Because legislatures attempt to encourage peer review by granting protections rather than requiring it
through mandates, a strategy that represents the proverbial carrot as opposed to the stick approach, the question should be asked: Do these peer review protection statutes effectively encourage peer review? This question is significant because the protection offered by state legislatures results in a loss of legal recourse by aggrieved parties. If these peer review protection statutes are ineffective, the loss of legal recourse is unwarranted.

There are many reasons why physicians and hospitals are reluctant to engage in peer review. A physician making an adverse peer review decision may face retaliatory litigation and nonlegal retribution, such as loss of referrals from the physician under review. Although peer review protection laws operate against legal retribution, they do not protect physicians from the nonlegal risks of participating in the peer review process. Hospitals also face nonlegal repercussions from the peer review process, such as loss of admissions and referrals from physicians sanctioned under the peer review process. Hence, powerful disincentives to perform peer review exist that counterbalance physicians' and hospitals' desire to improve the quality of health care through effective peer review. Peer review protection statutes, unfortunately, provide inadequate protection from these disincentives. Moreover, hospitals sometimes use peer review protection statutes to protect themselves from liability for failing to perform adequate peer review. In these cases, the statutes protect hospitals that are not engaging in the very activity the statutes seek to encourage.

If peer review is the key to enhanced quality of health care, stronger mandates to perform peer review and sanctions for failure to do so are necessary to cause effective peer review to take place. However, if such statutes remain in effect, they should be crafted to protect physicians and hospitals from liability and scrutiny when participants engage in good faith peer review, but should not protect participants who fail to fulfill their duties to perform peer review.

This study suggests that the peer review protection and reporting statutes are ineffective in promoting peer review and in ensuring that peer review reports are properly reported. Legislatures committed to achieving quality health care through peer review should consider additional methods of encouraging effective peer review. Although peer review is the generally accepted method of enhancing quality health care, the reliability of the system has also been criticized. This Article does not seek to answer the question of whether peer review, if occurring with appropriate frequency, can enhance the quality of health care. Legislatures that believe in it and desire to encourage effective peer review, need to consider new ways to promote the process because peer review protection statutes in large part are not working sufficiently by themselves.

III. THE PEER REVIEW PROCESS

A. MEDICAL PEER REVIEW

Physicians from a hospital's medical staff compose peer review boards. These physicians review the qualifications and practice patterns of physicians on the hospital's medical staff as well as new applicants. Peer review determines whether such physicians should be providing certain health care services in that institution and, if so, which procedures and treatments they are qualified to perform.

In the first half of the twentieth century, the medical profession developed peer review as a way to review the quality of the care rendered by physicians and surgeons. The purpose of peer review is to analyze critically the medical services rendered by physicians, and if deficiencies exist, either to prevent a physician with quality problems from continuing to provide such services or to cause the physician to improve the quality of services rendered. In 1952 the Joint Commission on Accreditation of Hospitals, now the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), began to require hospitals to perform peer review to qualify for accreditation. Over the second half of the twentieth century, medical peer review developed into the primary method of evaluating the quality of physician services at the hospital level. Today, peer review is performed in a variety of settings, such as part of the quality assurance program of a hospital or other health care institution, a medical society or a third-party payer of health care expenses. The analysis herein focuses on peer review in a hospital setting.
Although a hospital's governing body ultimately decides whether a physician should be permitted on the hospital's medical staff, the peer review process provides the basis for the medical staff's recommendation to the hospital board. Members of the hospital's medical staff review the qualifications, training and experience of both medical staff applicants and existing medical staff members to recommend to the governing body whether the individuals should be on the medical staff and which clinical privileges they may enjoy. The decision to offer a physician medical staff privileges is a yes or no decision. The decision as to which clinical privileges a person may enjoy if accepted onto the medical staff is a detailed process through which physicians are granted privileges to perform specific procedures. For example, a general surgeon may be granted the right to attend vaginal deliveries in the hospital, but may be denied the right to perform cesarean sections. Similarly, a general surgeon may be granted the privilege to perform an open cholecystotomy, but not a laparoscopic cholecystotomy a procedure generally reserved for a physician with specialized training. Even if a physician has the training to perform a specific procedure or treatment, the physician may be denied the privilege to provide the service if quality concerns have been raised regarding the physician's past provision of other services.

For initial applicants, the process involves the review of the applicant's training and previous clinical experience. This part of the process is often referred to as credentialing because it is based in large part on physicians' credentials, such as training, certifications and demonstrated competence. For existing medical staff members, the peer reviewers are also able to review quality assurance data, diagnostic and laboratory utilization reports, and other information regarding each staff member's actual practice at the hospital. Periodically, such information, along with any changes in the physician's training or other qualifications, is reviewed to determine if the physician may continue to practice at the hospital and, if so, what clinical privileges may be exercised. Although existing hospital medical staff members are generally required to submit to review every two years whether or not quality concerns have been raised, medical staffs and hospitals generally are empowered to review a physician's clinical privileges whenever there is a reason to believe that quality concerns warrant action prior to the next review. Inherent in peer review is the premise that information obtained in such review, if indicative of quality concerns regarding a physician's practice, may be used to determine whether the physician's privileges should be limited in some manner or be eliminated.

Peer review is only one mechanism to monitor and improve the quality of physicians. State licensing board disciplinary actions and the medical malpractice system are two other methods of preventing physicians from practicing substandard medicine. State licensing boards are empowered to address a physician's practice in an office setting while the hospital peer review process focuses on the physician's hospital practice. The malpractice system, in theory, improves the quality of health care by forcing physicians whose conduct falls below the standard of care to take remedial steps to improve the services they provide through the threat of civil liability. Despite the existence of these alternatives, peer review has become widely accepted as the primary means to weed out low quality physicians and to identify and offer assistance to physicians whose skills need to be enhanced in certain areas.

Whether or not peer review is occurring with adequate frequency, it remains the primary means of assessing physician quality within an institutional setting. Whether or not peer review, when performed, is reliable in measuring quality of health care has been questioned at times. A 1992 survey of all published studies from 1966 to 1990 that evaluated the effectiveness of peer review concluded that:

Overall, physician agreement regarding quality of care is only slightly better than the level expected by chance. This finding casts considerable doubt on the standard practice of peer assessment; thus, it poses a major challenge for those involved in quality assurance efforts given the central role of peer review in currently used methods.

If peer review is unreliable, then should peer review be the preferred method for enhancing the quality of health care services rendered in hospitals? Furthermore, if peer review is unreliable, it weakens the rationale underlying peer review privilege and immunities laws. These questions about the system's reliability in measuring physician quality may be particularly problematic for state legislatures. If peer
review is not as effective as it could be in enhancing quality health care solely because it is not being used with sufficient frequency, peer review protection statutes, coupled with mandates sufficient to compel appropriate peer review, may be an answer. If, however, the peer review system is inherently ineffective in identifying poor quality physicians, then offering peer review protections that adversely affect individual litigants is unjustified.

This Article suggests that if legislatures want to encourage effective peer review, they must require it because protective legislation has been ineffective. If mandates are adopted, keeping the peer review protection statutes in place may be appropriate in the spirit of fairness to the physicians and hospitals required to perform peer review. Without such mandates, however, the existing protection statutes do not appear to benefit the public and instead burden the judicial process.